IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1976

No. 75-554

FRANK S. BEAL, Individually and as Secretary of the Department of Public Welfare, Commonwealth of Pennsylvania, et al.,

Petitioners,

— vs —

ANN DOE, and a class,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF FOR *AMICI CURIAE*

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INTEREST OF AMICI CURIAE

Amici curiae respectfully submit this additional argument to supplement that filed by Respondents here-

in, Ann Doe and the class which she represents. Amici have obtained permission from counsel for both Petitioners and Respondents to submit this brief, and the consents obtained from the parties are on file herein with the Clerk of the Court.

While amici are confident that counsel for Respondents will fairly and fully represent the interests of the class he represents, amici believe that his arguments will primarily represent the interests of that class, and that a full airing of the issues presented by this case will be aided by the submission of arguments reflecting the viewpoint of other groups of directly affected individuals. Accordingly, amici hereby submit this supplemental argument, which represents the interests of a substantial segment of the medical profession, as well as the interests of concerned citizens' groups.

The medical organizations and individuals listed on the cover of this brief have a direct stake in the outcome of this controversy, since the decision to perform any abortion is one participated in equally by both physician and patient. The non-medical organizations appearing as amici are well-established citizens' groups whose members will be directly affected by the resolution of this case. Their views are reflected herein and advanced in the hope that these viewpoints will complement those of the Respondents and lead to the affirmation of the decision of the court below.

SUMMARY OF ARGUMENT

A. Pennsylvania attempts to justify its refusal to reimburse elective abortion costs on the ground that its Medicaid program covers only those medical services which are "medically necessary." Pregnancy, however, is a condition universally recognized as requiring some form of medical care, and there is no reason to consider elective abortions less "medically necessary" than alternative treatments which the State *will* pay for, *i.e.*, "therapeutic" abortions and live birth. Under the Medicaid statutes, the choice of treatment for a condition requiring medical care is a decision for doctor and patient only, and the State may not interfere with that decision.

B. Congressional intent in enacting Medicaid was broad enough to allow reimbursement of elective abortions. Its failure specifically to mention this procedure is no indication of congressional intent to exclude it, since the statutes mention no specific Medicaid procedures. Rather, when Congress has intended to exclude abortion from federal funding, it has done so explicitly. Its failure to exclude abortions from coverage of the 1972 family planning amendments therefore further indicates that this treatment is reimburseable under title XIX.

C. The decision to perform an elective abortion cannot arbitrarily be classified as "non-medical" by the State. Rather, this Court's decision in *Doe v. Bolton*, 410 U.S. 179 (1973), clearly indicated that this choice of treatment was a proper "medical" decision.

D. An erroneous interpretation of title XIX by the Department of Health, Education and Welfare cannot be accorded any special weight by a reviewing court. Rather, where an agency erroneously interprets a controlling statute, the courts are the final authority on statutory interpretation.

E. The State's objections to funding elective abortions are based on moral, not legal, grounds. Such grounds do not provide a permissible basis for legislative classification. Accordingly, state refusal to fund elective abortion on these grounds must be declared violative of title XIX.

F. Under the guarantee of equal treatment in title XIX, the State may not arbitrarily force pregnant women to submit to the least voluntary choice of treatment for the condition of pregnancy, since it does not impose similar restrictions on persons suffering from other conditions which require medical treatment.

ARGUMENT

Introduction

This Court's January 1973 decisions in *Roe v. Wade*[1] and *Doe v. Bolton*[2] determined that the right to obtain an abortion is a fundamental right which cannot be unreasonably regulated by the states. These decisions left open, however, the extent to which states may impose non-criminal restrictions upon the right to

[1] 410 U.S. 113 (1973).
[2] 410 U.S. 179 (1973).

abortion.[3] One such question, squarely presented by this case, is whether the federal government and the states must pay for abortions for women who are eligible participants in the Medicaid program and who cannot otherwise afford them.

The Medicaid program, a joint federal-state enterprise to provide essential medical services for the medically indigent, was established in 1965 by title XIX of the Social Security Act.[4] Title XIX requires participating states to provide enumerated medical services to individuals characterized as "categorically needy,"[5] and provides additional coverage for states which elect also to provide services to the "medically needy," individuals whose income is too great to qualify as categorically needy, but too low to cover the costs of medical care.[6]

Pennsylvania has elected to extend medical benefits to this "medically needy" group. 62 P.S. §441.1 *et seq.* It therefore extends coverage to both groups of patients for health services falling within several categories, such as "physicians' services," which are "medically necessary." Brief of the Petitioner, Supplemental

[3] Such issues include whether a state can require parental or spousal consent before allowing abortions, a question already resolved in the negative by this Court in **Planned Parenthood v. Danforth**, 44 U.S.L.W. 5197 (1976), and **Bellotti v. Baird**, 44 U.S.L.W. 5221 (1976). Another such issue is whether public hospitals must perform abortions, a question presently before this Court in **Poelker v. Doe**, No. 75-442. On the other hand, reasonable regulation of medical standards has been held appropriate. **Connecticut v. Menillo**, 423 U.S. 9 (1975).
[4] 42 U.S.C. §1396 **et seq.** (1970).
[5] 45 C.F.R. §249.10(a) (1) (1975).
[6] 42 U.S.C. §1396a (a) (10) (B) (1970).

Appendix at 61, 68 (quoting relevant state regulations). Therefore, should this Court determine that elective abortions constitute "medically necessary" treatment, both groups of Medicaid recipients will be eligible for reimbursement of those costs in Pennsylvania.

Plaintiffs (Respondents here) have challenged Pennsylvania's Medicaid statutes and regulations on the grounds that (1) title XIX requires funding of all abortions obtained by eligible Medicaid recipients, not just those abortions classified by Pennsylvania regulations as "medically necessary;" and (2) the State's policy of reimbursing only such "medically necessary" abortions violates the Equal Protection Clause of the Fourteenth Amendment and the right to privacy as recognized in *Roe v. Wade*,[7] and further defined in *Planned Parenthood v. Danforth*[8] and *Bellotti v. Baird*.[9] Amici agree that the Pennsylvia Medicaid provisions are invalid on either of these grounds.

A. Pregnancy Is Clearly A Condition For Which Some Form Of Physician Care Is "Medically Necessary." Patient Choice Of The Form Of Treatment For That Condition, Absent Some Legitimate State Interest In Protecting The Mother's Health, May Not Be Restricted By A State Medicaid Program.

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[7] 410 U.S. 113 (1973).

[8] 44 U.S.L W. 5197 (1976).

[9] 44 U.S.L.W. 5221 (1976).

The State attempts to justify its refusal to reimburse health care providers for "non-therapeutic" abortions on the ground that the federal Medicaid law authorizes payment of federal funds only for services which are "medically necessary,"[10] explaining that it "has limited the coverage of its medicaid program to those services which are medically necessary at the time of their utilization." Brief of the Petitioner at 11. This argument clearly rests on the assumption that birth is somehow more "medically necessary" than abortion, since the State *will* reimburse costs of prenatal, obstetrical, and post-partum care in cases where it is unwilling to pay the costs of an abortion.

There is no physiological or psychological basis for labeling the medical services attendant to birth more important or necessary than those attendant to abortion. When a woman is pregnant she requires medical care. The sole choice involved is birth or abortion and either must be provided by a physician.[11] The distinction here contended for by Pennsylvania rests upon its social policy preference, not a medical or legal determination. While the State might perhaps choose not to pay for *any* medical services for pregnancy, it cannot pay for

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[10] It bases this argument on the preamble to the Act, which describes the principal goal of title XIX as providing "medical assistance on behalf of . . . individuals, whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. §1396 (1970).

[11] **Connecticut v. Menillo, supra**, holding that, while a state may not restrict a woman's decision to terminate her pregnancy, it **may** require that abortions be performed by competent personnel.

one form of treatment (*i.e.*, childbirth) and not for the other (*i.e.*, abortion).[12]

While participating states have considerable latitude in designing their Medicaid programs,[13] they must exercise their discretion within statutory parameters. It is possible that Congress intended the states to choose the medical conditions they would cover and to decide whether a given treatment for such conditions was reasonably safe.[14] Once these two preliminary decisions are made, however, the State has no further legitimate interest in restricting the mode of treatment for a Medicaid-authorized condition. Rather, as this Court explained in *Doe v. Bolton*,[15] and reiterated in *Danforth*[16] and *Bellotti*,[17] such a choice must be made solely by physician and patient. The Medicaid statute nowhere prohibits disbursements of funds for abortion; absent such a statutory prohibition, the only congressional guidance as to reimburseable treatment is that the states must uniformly reimburse medical costs for all listed categories of health care received by eligible patients.[18] Therefore, if the State will reimburse costs of "necessary" abortions and of live birth as constituting "medically necessary" responses to the condition of pregnancy, it must, under the statutory directive, also reimburse the

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12 **Planned Parenthood Assn. v. Fitzpatrick**, 401 F. Supp. 554, 581 (E. D. Pa. 1975).

13 42 U.S.C. §§1396a(a) (10), (14) and (17), 1396d (a), (f) and (c) (1970).

14 42 U.S.C. §§1396a(a) (17) and (30), 1396b(g) (1970).

15 410 U.S. 179 (1973).

16 44 U.S.L.W. 5197 (1976).

17 44 U.S.L.W. 5221 (1976).

18 42 U.S.C. §1396a(a) (10) (B), (C) (1970).

costs of elective abortions, as these constitute medical treatment necessary for a medical condition requiring treatment, just as do the other true categories.

A number of courts have joined the court below in recognizing this simple argument. In *Roe v. Norton*, for example, the court recognized that

> [p]regnancy is plainly a physical condition which requires medical attention. The nature of the services to be rendered is a matter between patient and doctor. . . . The care and services rendered in [the case of either live birth or elective abortion] would be equally "necessary" if such a showing were required by Title XIX.[19]

Adopting this reasoning, the court below properly found that once a participating state has defined a condition for which treatment is "necessary," it is then up to the attending physician, not the State, to elect an appropriate treatment for the condition.[20]

The term "medical necessity" as used herein focuses on whether a condition requires treatment, but the term's proper usage has been the source of considerable judicial confusion and has been interpreted in varying

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19 552 F.2d 928, 934 (2d Cir. 1975). **Accord: Klein v. Nassau County Medical Center**, 347 F. Supp. 496, 500 (E.D.N.Y. 1972); **Doe v. Rose**, 499 F.2d 1112, 1116, (10th Cir. 1974); **Coe v. Hooker**, 406 F. Supp. 1072, 1081 (D.N.H. 1976). While the **Klein** decision was vacated and remanded for reconsideration in light of **Roe** and **Doe**, 412 U.S. 924-25, the court's reasoning was so sound that it has been universally accepted, providing the underpinning of most of the Medicaid abortion decisions to follow.

20 **Doe v. Beal**, 523 F.2d 611, 620 (3rd Cir. 1975).

ways. It is therefore worthy of some further treatment here. The question is how Congress intended the term to be defined. Since there is no evidence that Congress mandated a national definition, it is likely that it expected states to develop such standards on some rational basis, probably in conjunction with the medical profession.[21] Courts have interpreted the term in the manner advanced by amici herein,[22] but they have also interpreted it as limiting the *persons* eligible for Medicaid rather than the *conditions* for which Medicaid may be supplied.[23] Under either interpretation, however, several courts have held reimbursement of elective abortion costs to be mandatory.

Yet another interpretation of the term from the medical community itself also leads forcibly to a conclusion that title XIX mandates coverage of elective abortions. This definition considers "medically necessary" care to be that treatment which is responsive to the problem for which it is offered.[24] Under this defin-

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[21] The PSRO Law, 42 U.S.C. §1320c-1, enacted in 1972, delegates the function of setting standards for medical necessity and applying them for Medicaid patients to local groups of physicians. Although they will begin with inpatient hospital procedures, they will eventually review outpatient services as well.

[22] See note 19 **supra** and accompanying text.

[23] **E.g., Roe v. Norton**, 380 F. Supp. 726, 728-29 (D. Conn. 1974), although the court also subsequently decided that once a state determines that a **condition** requires medical treatment, the choice of treatment can be made only by physician and patient. 380 F. Supp. at 729.

[24] For an application of this definition, **see** Bunker, **Elective Hysterectomy: Pro and Con**, 295 **N. Eng. J. Medicine**, 267 (1976).

ition, one must first identify the problem for which the medical care is offered and then determine whether it is a safe and effective treatment for the condition. If the condition is pregnancy, it is a condition universally recognized as necessitating medical treatment, although it is not a pathology.[25]

Since pregnancy is a condition requiring medical attention, the second step is to determine whether abortion is a safe response to it at certain medically recognized stages. Neither the choice of live birth nor that of abortion can be considered "unnecessary" under this analysis, despite the fact that those treatments present different outcomes as a result of the treatment.

An analogous situation is presented by a diagnosis of kidney disease, where the choice of treatment is transplant or dialysis. Each choice produces significantly different outcomes with different effects on the patient's mental and physical health, but this by no means indicates that one choice is less "necessary" than the other. As it happens, this particular condition is one which would be reimburseable under the challenged state regulations regardless of which treatment for that condition the doctor and patient elected. While the choice of treatment would be predicated upon consideration of a number of individual factors known only to physician and patient, they would at least not be forced to give overriding consideration to an arbitrary State determination that one form of treatment was more

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[25] **Klein v. Nassau County Med. Ctr.**, 347 F. Supp. 496, 500 (E.D.N.Y. 1972).

moral (*i.e.*, more "necessary" under a State definition of that term) than the alternative choice.

In *Doe v. Bolton*,[26] the tacit assumption that pregnancy is a condition requiring medical treatment lay at the heart of this Court's determination that the right to privacy includes the abortion choice. That case determined that the right of privacy does encompass this choice of method of treating pregnancy, a choice to be made by the woman with the advice and counsel of her physician. It is not for the states to substitute their judgment for that of a physician on the appropriateness of a given choice of treatment. If a physician's choice of treatment is in fact unethical, the physician should be left to be disciplined by his licensing board,[27] but the state may not make the blanket assumption that all abortions categorized by its regulations as "non-therapeutic" are in fact "medically unnecessary."

B. Congressional Intent In Enacting Medicaid Was Broad Enough To Encompass Any Medical Treatment, Then Legal Or Not, Which Might Be "Medically Necessary."

Petitioners herein argue that because elective abortions were illegal in most states when title XIX was enacted, the court below erred in holding that Congress could have required payment for such abortions. Brief of Petitioner at 13. Rather, Petitioners argue, the Act should be construed in light of conditions existing at the time of its passage. *Id.* at 14. In

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[26] 410 U.S. at 192-93.

[27] 410 U.S. at 200.

fact, however, amici respectfully submit that congressional intent in enacting title XIX was clearly broad enough to encompass funding of any treatment which might be medically necessary, regardless of whether that treatment might have been considered necessary in 1965.

Why the existence in 1965 of laws invalid on their face should act as any kind of limitation on the scope of title XIX is not readily discernible. Furthermore, this argument overlooks the impact of the 1972 family planning amendments to the Medicaid law, which are by implication wide-sweeping and without limitation.[28] Also indicating that title XIX does not preclude Medicaid payments for non-therapeutic abortions is the fact that Congress has entertained, but refused to enact, two specific amendments to prohibit the use of federal Medicaid funds for abortion.[29] The history of congressional activity on abortion since 1965 makes it clear that when Congress has sought to exclude abortion from family planning programs, it has done so explicitly.[30]

The legislative history of the 1972 family planning amendments does not mention an intent either to include

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[28] 42 U.S.C. §§1396d (a) (4) (C) and 602 (a) (15) (1970).

[29] H.R. 3153, 93d Cong., 1st Sess. §198B. The bill became law, P.L. 94-48, without this provision. The Bartlett amendment to the 1974 H.E.W. Appropriations Bill would have prohibited using H.E.W. funds, including Medicaid, for abortions. Cong. Rec. S. 16832 (Daily Ed., Sept. 17, 1974).

[30] Such enactments are discussed at some length in **Roe v. Ferguson**, 515 F.2d 279, 283 (6th Cir. 1975), although that court considered such provisions indicative of congressional intent generally to **exclude** coverage of abortion under title XIX.

or exclude abortion as a family planning service.[31] As evidence that the term *does* include abortions is the fact that other federal statutes have expressly exempted abortion for family planning programs,[32] as well as the standard practice of public health experts of including abortions in their definition of family planning services.[33] Abortion is a viable method of handling contraceptive failure and meets family planning needs where contraception has not been used or provided. It is therefore necessary in a variety of circumstances.

If elective abortion is not available in the early stages of pregnancy, physicians may be forced to use alternative control methods for women for whom childbirth involves serious adverse health risks, despite the fact that health risks attendant to oral contraceptive use are increasingly recognized as greater than those involved in using an alternative contraception method with abortion as a backup.[34] The availability of abortion therefore expands physician freedom of choice among medically appropriate procedures in selecting the optimal treatment for individual patients, and regulations or statutes limiting this freedom are not constitutionally acceptable.[35]

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[31] S. Rep. No. 92-1230, 92d Cong., 2d Sess. 297 (1972).

[32] **E.g.**, Congress obviously felt abortion **could** be classified as a family planning service when it expressly exempted it from coverage under title VIII of the Public Health Service Act, 42 U.S.C. §300a(b) (1970).

[33] There is relatively uniform concensus among health care professionals that family planning services include such specific techniques as contraception, abortion, sterilization and treatment for infertility. Wallace, Goldstine, Gold & Inglesby, **A Study of Title XIX Coverage of Abortion, Am. J. Pub. Health**, 116-1120 (August 1972).

[34] **Report of the President's Commission on Population Growth and the American Future**, 103 (GPO 1972). One authority has stated that the best method of family planning is a perfectly safe, if not perfectly effective, contraceptive method with early termination of pregnancy available as a back-up. C. Tietze, **Induced Abortion: A Factbook, Reports on Population/Family Planning**, 1973. Sterilization is fully effective but is irreversible, and so unacceptable to some. E. Dunbar, **Sterilization, Foolproof Birth Control**, 22 (L. Lader, ed. 1972). The intrauterine coil is only partially effective and impossible for many women to retain. H. Edey, **Sterilization, Foolproof Birth Control, supra**, at 42. Contraceptive pills are effective, if properly used, but may produce adverse side effects in some women. **Id.**

The Medicaid statute's failure to mention abortion cannot be considered evidence of congressional intent to exclude it, since the statute mentions *no* individual medical procedure, only the general service categories: *e.g.* physician, inpatient and outpatient, and nursing home services. The statute's omission of specific reference to abortion is therefore no more noteworthy than its failure to mention such treatment as dialysis or appendectomy.

Furthermore, it must be remembered that abortions to save the life (and, in some states, the health) of the mother *were* legal in 1965 and were being funded at that time. The State's assertion that the illegality in 1965 of abortions must bar their coverage under title

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[35] 44 U.S.L.W. at 5204-05, wherein this Court held that Missouri's flat prohibition of saline amniocentisis as an allowable abortion technique was unreasonable and arbitrary.

XIX is therefore an oversimplification of existing conditions. Restrictions on abortion which did exist in 1965 were, after all, unconstitutional invasions of the right to privacy, and should therefore not serve to freeze allowable treatment to those kinds of abortions permissible at that time. Rather, as the definition of legal treatment for any given condition expands, available funding should follow the state of the law. This should be true for any given medical procedure, whether it is elective abortion or treatment for some other condition.

Finally, it is agreed by all of the parties hereto that Medicaid leaves to the states the task of defining the "amount, scope and duration" of medical care.[36] This allows the states great latitude in electing whether or not to treat given conditions. It does not, however, indicate that the states are to freeze reimburseable modes of treatment to those available in 1965. If the states wish to refuse reimbursement for some treatment which is recognized as safe and effective by the medical community, their only option under this statute must be to refuse payment for *all* available modalities of treatment for a given condition — *i.e.*, their choice is limited to refusing to recognize a condition as one for which physician services are "medically necessary."

C. A Doctor's Decision To Perform An Elective Abortion Cannot Be Classified By The State As "Non-Medical" And Therefore Not "Medically Necessary."

The State has argued that when a physician de-

[36] 42 U.S.C. §§1396(a) (10), (14) and (17).

cides to recommend a "non-therapeutic" abortion, he is making a decision which is somehow non-medical, which he is therefore not professionally qualified to make, and which the State may preclude him from making. Brief of Petitioner at 18. While this argument is somewhat nebulous, it seems to focus on an assertion that physicians lack expertise "with respect to a patient's social and economic needs." *Id.* at 19. The challenged state regulations do, however, permit abortions which are made to preserve the "mental health" of the mother; considerations of mental health and "social and economic needs" hardly appear to be mutually exclusive. It is also difficult to explain why general practitioners are apparently qualified to make decisions regarding a patient's "social and economic needs," since few general practitioners have significant expertise in psychiatry or psychology. In addition, during the first trimester of pregnancy the State has no legal right to make such distinctions.[37] The distinction the State seeks to make is not clear, let alone made on a rational basis to protect the health of the pregnant woman.

In fact, physicians often choose one alternative treatment over another on the basis of such considerations as patient emotional stability and social and economic needs. While general practitioners may not be expertly trained to treat such needs, they have traditionally attempted to do so, and this Court has expressly recognized the validity of a doctor's selection of treatment for a physical condition which is heavily influ-

[37] **Roe v. Wade**, 410 U.S. at 163; **Planned Parenthood v. Danforth**, 44 U.S.L.W. at 5204-05.

enced by such factors. In *Doe v. Bolton*,[38] the Court assumed that physicians make an abortion decision based not only on physical, but also on emotional, psychological and familial factors, as well as the woman's age. A proper "medical" decision, considering all of these subjective factors, might not clearly appear necessar to preserve mental health, but could instead more clearly meet the patient's "social and economic needs."

Any attempt to perpetuate standards for "medically necessary" abortions which is premised upon this quagmire of subjective and tenuous distinctions between "medical" and "non-medical" decisions is both unwise and impermissible. Instead, such standards must allow reasonably wide physician choice of permissible treatment for any condition for which medical treatment is medically necessary. The State can participate no further in electing to reimburse or not to reimburse once it has recognized a given condition as requiring medical treatment.

Such a construction of title XIX does not force all physicians or all hospitals to perform abortions. Medicaid is a "vendor payment program," designed to reimburse providers of health care for services rendered to program beneficiaries. 42 U.S.C. §1396d(a) (1970). It will pay for health services if a recipient can locate a provider to treat her, but it does not guarantee the availability or accessibility of services. Thus, a finding that elective abortions must be reimbursed under Medicaid does not destroy individual physicians' free-

[38] **410 U.S. at 192-93.**

dom of choice in electing whether or not to perform abortions at all.

D. This Court Is The Final Authority In Interpreting The Medicaid Statutes.

Appellants rely upon the Department of Health, Education and Welfare's [H.E.W.'s] interpretation of the question at issue herein, because H.E.W. has concluded that funding of elective abortions is permissible but not mandatory under the Medicaid statute. While approval from a regulatory agency charged with administering a particular program is entitled to weight from the courts, it is equally clear that where that administrative interpretation is not correct, it must be invalidated by the courts.[39] In *Vialpando v. Shea*, the United States Court of Appeals for the Tenth Circuit refused to accord any special weight to H.E.W.'s approval of a Colorado AFDC regulation, explaining that "[t]his principle [of according weight to agency opinion] is inapplicable when a departmental interpretation is inconsistent with controlling statute."[40]

As was the case in *Vialpando*, H.E.W.'s interpretation of Medicaid requirements is inconsistent with the legislative intent and express wording of the statutes.

[39] **Vialpando v. Shea, 475 F.2d 731 (10th Cir. 1973), aff'd, 416 U.S. 251 (1974); Townsend v. Swank, 404 U.S. 282 (1971); King v. Smith, 392 U.S. 309, 333 (1968); Red Lion Broadcasting Co. v. FCC, 395 U.S. 367 (1969).**

[40] **475 F.2d 731, 735 (10th Cir. 1973), citing Townsend v. Swank, 404 U.S. 282, 286 (1971).**

It is therefore entitled to no special deference by this Court.

E. The State's Real Objections To Funding Elective Abortions Are Based On Philosophical, Not Legal, Grounds. Such Grounds Do Not Constitute A Permissible Reason For Refusing Medicaid Payments To Eligible Recipients.

In a political system founded on the belief in a marketplace of ideas, in which all views are tolerated, the State may not impose one philosophy to the exclusion of all others on its citizens. Our laws reflect these fundamental concepts, and the trial court in this case properly recognized that "the law does not represent itself as a moral code."[41] The State's elimination of elective abortion from Medicaid eligibility represents an attempt to substitute semantics for meaningful legal standards, and must be recognized as a moral decision rather than a legal one.[42] Such standards do not provide a rational basis for legislative classification within the parameters of title XIX.

The State's difficulty in establishing that its position is legal rather than moral is underscored by its argument that "medical necessity" can be equated to "economic" necessity. Asserting that "the touchstone of Pennsylvania's Medicaid program is medical necessity," the State reasons that it is compelled by limited re-

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[41] **Doe v. Wohlgemuth**, 376 F. Supp. 173, 179 (W.D. Pa. 1974).

[42] **Coe v. Hooker**, 406 F. Supp. 1072, 1083 (D.N.H. 1976), **citing Klein v. Nassau County Medical Center**, 347 F. Supp. 496, 500 (E.D.N.Y. 1972); **Doe v. Westby**, 402 F. Supp. 140 (D.S.D. 1975).

sources to "generally limit its medicaid program to cover only the most urgently needed medical services." Brief of Petitioner at 11-12. This argument is ill-advised.

The weakness of this position is that Pennsylvania *does* fund what it terms "necessary" abortions, as well as all of the costs attendant to live birth. Accordingly, the argument that Pennsylvania's refusal to fund elective abortions has an economic basis simply makes no sense, since a first-trimester abortion must inevitably be less costly to the State than prenatal, live birth, and post-natal care. An elective abortion is at least no more expensive than a "therapeutic" abortion.[43]

That the State relies on a claim of economic justification to support a position which causes it greater expense than the treatment it refuses to reimburse is by itself a clear indication that the reasons it states in support of its position are not its real reasons. Amici herein respectfully submit that whatever the State's moral position may be, it may not impose that ethos on all its citizens.

F. The State Has No Legitimate Interest In Refusing To Finance Elective Abortions.

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[43] The weakness of this economic necessity argument has been recognized on several occasions by other courts "Certainly the denial of medical assistance does not serve the State's fiscal interest, since the consequence is that the indigent may then apply for prenatal, obstetrical and post-partum care and for prenatal support for the unborn child." **Klein v. Nassau County Medical Center**, 347 F. Supp. 496, 501 (E.D.N.Y. 1972). "We observe that in this situation the state pays a greater sum of money and clearly does not 'conserve limited state resources.'" **Planned Parenthood Assn. v. Fitzpatrick**, 401 F. Supp. 554, 580 (E.D. Pa. 1975).

The court below properly held that the "comparability section" of the Medicaid statute[44] requires equitable treatment of recipients whose physicians choose various modes of therapy for the same condition. Examining Medicaid's statutory language and purposes, the court concluded that, while the states have considerable latitude in designing their Medicaid programs to meet both beneficiary needs and state fiscal needs,[45] they must exercise that discretion within the confines of the statutory limitations.[46]

In defining those limitations, the court interpreted 42 U.S.C. sections 1396a(a) (10) (B) and (C), which require that medical assistance available to eligible recipients cannot be "less in amount, duration or scope than the medical assistance made available to any other such individual." The court held that this language prescribes equality among Medicaid recipients and that restricting payment for abortion forces "pregnant women to use the least voluntary method of treatment, while not imposing a similar requirement on other persons who qualify for aid." 523 F.2d at 619. This judicial implication of a statutory "equal protection clause" is fully justified by the express wording of the statute, as evidenced by subsequent decisions which have also adopted this approach.[47] It is also noteworthy

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[44] 42 U.S.C. §1396a (a) (10) (B) and (C) (1970).

[45] 523 F.2d at 616.

[46] Id. at 616-19.

[47] Coe v. Hooker, 406 F. Supp. 1072, 1082-84 (D.N.H. 1976); Doe v. Westby, 402 F. Supp. 140, 143 (D.S. Dak. 1975); Doe v. Myatt, No. 43-74-48 (D.N. Dak., Oct. 30, 1975).

that no subsequent decision has specifically rejected this approach.

There are no rational state grounds for refusal to reimburse elective abortions since the health risks of this procedure are not high enough to invoke state interest in preserving the life and health of the mother. If high risks attend any abortion, they accompany those abortions which the state currently *will* reimburse — the "medically necessary" abortions. In the case of elective abortion, however, the patient's health is not already impaired, and the attendant risks of such surgery are even less for her than for the patient undergoing ordinary childbirth.

The Medicaid program has as one goal the provision of medical care in "the best interests of the recipients." 42 U.S.C. section 1396a(a) (19) (1970). Since first-trimester abortion in fact entails *lower* health risks than delivery, an election of this alternative is solely a choice for physician and patient.[48] Under the guarantee of equality inherent in the Medicaid statutes and regulations, the State may not interfere with this decision.

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[48] Coe v. Hooker, supra, 406 F. Supp. at 1081, citing Roe v. Wade, 410 U.S. 113, 149 (1973); Doe v. Beal, 523 F.2d 611, 622 (3rd Cir. 1975).

CONCLUSION

Title XIX mandates reimbursement of costs for treatment of any condition for which physicians' services are "medically necessary," once a state has elected to provide *any* medical services for that condition. The Medicaid program is a broad and flexible one, allowing reimbursement for modes of treatment not available at the time of the statute's enactment in 1965. State opposition to a form of treatment based solely on moral grounds, rather than on proper interpretation of the applicable statutes, cannot sustain that position.

In an analogous situation, this Court has held that such interests are not proper grounds for state regulation. In *King v. Smith*,[49] invalidating an Alabama regulation which restricted AFDC payments for children of "immoral" mothers, this Court reasoned that state restriction of welfare funding on moral grounds "plainly conflicts with federal law and policy." As no legitimate state interests other than moral one support the Pennsylvania policy challenged herein, the courts below properly held that this policy irreconcilably conflicts with title XIX.

On the basis of the foregoing arguments and authorities, the decision of the lower court should be affirmed.

Dated this tenth day of September, 1976.

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[49] 392 U.S. 309 (1968).

Respectfully submitted,

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